INVESTIGATION REPORT

SUDDEN/UNEXPECTED DEATH OF JB

A 26-year-old male resident of Southeastern Virginia Training Center suddenly died due to complications associated with a diagnosed, but untreated panic disorder.

DRVD Case No. 99-0089 DD

Department for Rights of Virginians with Disabilities
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I. INTRODUCTION

This report is a summary of the findings from a six-month investigation conducted by the Department for Rights of Virginians with Disabilities ("DRVD") into the sudden death of JB, a twenty-six (26) year old male resident with autism and mental retardation at Southeastern Virginia Training Center ("SEVTC") on Monday, February 15, 1999. JB was pronounced dead at 5:35 p.m. at Chesapeake General Hospital in Chesapeake, Virginia, after several attempts to revive him. JB apparently died due to complications associated with a diagnosed, but inappropriately treated panic disorder.

JB's mother called DRVD on February 17, 1999, and requested assistance in determining the cause of JB's death. The case was assigned to Pamela Johnson, Staff Attorney, on February 18, 1999, and the investigation was immediately initiated pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 1994 [42 U.S.C. § 6042(a)(2)(B)], as amended.

The investigation involved the following action:

1. Initial conversation with JB's mother and verification of intake information
2. Written notice of investigation to Director of SEVTC.
3. Written request for resident records to SEVTC
4. Written request for medical records from Chesapeake General Hospital
5. Written request for autopsy report to Medical Examiner

6. On-Site Visit and Tour with SEVTC Health Services Director
7. Witness Interviews on 2/26/99, 4/20/99, 5/2/99, 6/11/99
   - JB's mother
   - Consulting Neurologist
   - Dr. JB's Primary Care Physician
   - SEVTC Medical Director
   - JB's Treating Psychologist
   - Dr. , JB's Treating Psychiatrist
   - JB's Primary Nurse
   - SEVTC Program Manager
   - JB's Team Leader
   - Caregivers #1-#4
   - SEVTC Speech Pathologist/Shift Leader
8. Several calls to Medical Examiner's Office to check status of final report.
9. Calls to Chesapeake General to check status of records request
10. Review of resident records from SEVTC
11. Review of medical records from Chesapeake General Hospital
12. Review of autopsy report with Medical Examiner
13. Review of three videotapes of JB
14. Intra-agency review of medical expert's report
15. Medical Expert's review of medical records and witness testimony
16. Meeting with mother and sister of JB regarding investigation and expert's report

II. PURPOSE

DRVD investigates this matter to determine whether SEVTC staff and JB's treatment team met the standard of care in providing appropriate medical treatment and care to JB.

III. BACKGROUND

JB was a twenty-six-year old, Black male who was admitted to SEVTC on August 15, 1989, with diagnoses of infantile autism and severe mental retardation.[1] Since eighteen months of age, JB exhibited symptoms of both conditions, and was primarily cared for at home by his parents and an older sister.[2] However, JB received services from a number of different organizations such as the Kirk-Cone Rehabilitation Center (Chesapeake) in 1977; the Southeastern Cooperative Education Programs (SECEP) in Norfolk and Virginia Beach, Virginia; the DeJarnette Center (2/11/85 through 2/18/86) and the Autistic College in southeastern Virginia in 1989, due to severe behavioral problems and self-injurious behavior (SIB).[3]

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[1] February 16, 1999, SEVTC Death Summary
[2] Id.
[3] Id.

After the death of JB's father in February 1989, JB's mother was no longer able to physically care for him, and admitted JB to SEVTC as a permanent resident.[4] At the time of his admittance to SEVTC, JB was five feet, five inches, and weighed 165 pounds.[5] JB's family medical history includes colon cancer (father) and hypercholesterolemia (mother).[6] He has one older sister who is not developmentally disabled.

IV. CIRCUMSTANCES SURROUNDING DEATH OF JB

A. SEVTC'S Treatment and Care of JB

His mother admitted JB to SEVTC on August 15, 1989.[7] At that time, JB's diagnoses were moderate mental retardation with an autistic disorder, epilepsy (grand mal), seasonal rhinitis, disruptive disorder, diphydrotic eczema, panic disorder without agoraphobia, and schizophrenia of a chronic undifferentiated type.[8] However, there is no clinical information in JB's record to support the diagnosis of schizophrenia or comments regarding associated symptoms.

JB's care was coordinated by a treatment team comprised of Dr. , JB's psychiatrist; SEVTC psychologist; Dr. JB's primary care physician; SEVTC Program Manager; SEVTC Team Leader; JB's primary nurse; JB's mother, and sometimes JB.[9] Dr. is a private practitioner specializing in child and adolescent psychiatry who consults with SEVTC.[10] Dr. works on a contractual basis with SEVTC through Eastern Virginia Medical School.[11] Interdisciplinary Team meetings were also held with the Team Leader, Program Manager, JB's mother and direct care staff present to address everyday progress and the concerns of JB's mother.[12]

To control JB's self-injurious behavior, he was placed on several psychotropic medications, such as Ritalin, Tegretol, Lithium, and Anafranil, which either proved ineffective or caused JB to experience severe dyskinesia and other adverse reactions.[13] JB's maladaptive behaviors included slapping, scratching, pinching himself, and pulling his hair. His disruptive behaviors included aggression toward others, pulling staff and/or peers, attempting to push or kick windows, or attempting to leave or run away from assigned areas.[14] Data indicated that self-injurious behaviors occurred during 150-200 half-hour intervals per month and disruptive episodes ranged between five and twenty episodes monthly.[15]

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[4] Id.; Interview with JB's mother (2/26/99)
[5] Interview with JB's mother
[6] Bimonthly QMRP Reviews
[7] SEVTC Death Summary-February 16, 1999
[8] Bimonthly QMRP Reviews; Annual Psychological Update 7/1/98
[9] Interview with JB's mother
[10] Interview with Dr.
[11] Interview with Dr.
[12] ID Team Minutes
[13] SEVTC Death Summary
[14] JB's Annual Psychological Update – 7/1/98
[15] Id.

These behaviors were managed through a treatment plan that included Differential Reinforcement Behavior (DRO), redirection, and psychotropic medications (Clozaril, Depakote, and Xanax).[16] JB also continued to display behaviors resembling panic attacks and obsessive-compulsive behavior.[17] Mechanical restraints (four-point) were also used on an emergency basis for disruptive behaviors when redirection was unsuccessful and when JB appeared to become a danger to himself and others.[18]

JB's panic attacks were exhibited in several different forums, including his cottage, classroom, and his bedroom.[19] During these panic attacks, JB would exhibit rolling back of his eyes, heavy sweating, hopping around, mouth and hand tremors, drooling, rapid heart beat, hyperventilation, arching of his back, repetitive motions, and moaning.[20] JB's attacks would last approximately one half-hour.[21] Staff would allow JB to work himself through these attacks for observation purposes or give JB Ativan to stop the attack.[22]

In 1992, the then SEVTC consulting psychiatrist, placed JB on Clozaril (250 mg TID), a new psychotropic medication.[23] JB's mother consented to this medication administration after being informed of the risks and benefits of the drug.[24] JB's mother expressed concerns that the long-term effects of the drug were unknown, but thought that the immediate benefits outweighed the risks.[25]

In 1993, JB was placed on Ativan (2 mg) on a regular basis as a PRN medication to control his episodes of severe anxiety and disruptiveness.[26] JB's anxiety seemed to decrease with the Ativan.[27] In 1994, JB had a one-time grand mal seizure after a reduction in Ativan, and experienced more frequent (2-3/week) episodes of anxiety.[28] JB did not have a history of seizures.[29]

In 1996, JB was placed on Depakote (500 mg/day), an anti-convulsant drug, to help reduce his continued anxiety and panic attacks, which included severe hyperventilation.[30] On December 29, 1996, JB also had a falling down episode and received emergency treatment at Chesapeake General Hospital for an "acute altered mental status, episodic, etiology uncertain.[31]

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[16] Id.
[17] Id., Interview with Caregiver 1
[18] Annual Psychological Update – 7/1/98
[19] Videotapes of JB
[20] Id.; Interviews with JB's mother, Caregiver 1 and Treating Psychologist
[21] Videotape of JB – neurologist consult
[22] Id.
[23] SEVTC Death Summary
[24] Id.
[25] Id.; Interview with JB's mother
[26] Id.
[27] Id.; Interview with JB's mother
[28] Id., Interview with JB's mother; Chesapeake General Hospital ER Report-11/27/94
[29] Interview with JB's mother
[30] Id.
[31] Chesapeake General Hospital Emergency Treatment Record – 12/29/96

The ER report referenced the chief complaint as an anxiety attack and stated "anxiety and hyperventilation in the past."[32] In 1997, he was also placed on Xanax (1mg TID) to reduce the panic attacks. [33]

As a result, JB's panic attacks decreased significantly, according to SEVTC. These attacks usually occurred five to ten times per month, but after being placed on Xanax, they occurred one to two times per month.[34]

In 1997, JB also had a fainting spell coming from a classroom, and in 1998, while on a beach.[35] In March 1998, JB had a major episode of hyperventilation and fatigue after working out on a treadmill.[36] Therefore, a stress test was done which showed that JB's rhythms were within normal limits.[37]

On September 9, 1998, JB was taken to the ER at Chesapeake General Hospital for bee stings.[38] The record again mentions that JB became "agitated consistent with his usual panic attacks according to Southeastern Virginia Training Center staff" and the final diagnosis was a panic attack.[39]

DRVD obtained three videotapes from SEVTC, which showed JB in three different settings at the training center. Several staff members informed DRVD that there were two videotapes of JB filmed while he was in his panic phase. An SEVTC staff member later stated that the tapes had been erased or unfound and therefore, unavailable for DRVD to view. It was later confirmed that there were three videotapes (neurologist consult, late afternoon lunch, and classroom) and SEVTC provided these tapes after repeated requests for this evidence over a two-month period.

All three videotapes showed JB in a very excited emotional state in which he exhibited the following behaviors: tremors of the mouth and hands; hyperventilation; a fearful, fixed gaze; pacing; backwards hopping; spinning in place; pulling on staff; moaning; rolled back eyes; reaching for staff keys; reaching for restraints; bouncing on bed while in restraints; and minimal responsiveness to staff's calming conversation.

In the lunch tape, JB builds up to a panic attack apparently because there was a mix-up in lunches and staff was late getting them to JB's cottage. In the other two tapes, JB is already in the midst of a panic attack and staff is attempting to respond to JB's behavior.

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[32] Id.
[33] Interview with JB's mother, SEVTC Death Summary
[34] Annual Psychological Update – 7/1/98
[35] Interview with JB's mother
[36] SEVTC Death Summary; Interview with JB's mother
[37] Chesapeake General Hospital (CGH) Cardiology Treadmill Stress Test Report – 3/24/98
[38] Chesapeake General Hospital Emergency Treatment Record – 9/9/98
[39] Id.

Outside of the care given for JB's self-injurious, maladaptive, and disruptive behaviors, JB's treatment focused on helping him develop self-help skills, basic social skills, independent living skills, pre-vocational and vocational skills, and communication skills.[40]

B. Sequence of Events Leading Up To Death of JB

JB's mother was very concerned about JB's panic attacks and the continued potential for seizures, which increased with the use of Clozaril.[41] She was also concerned about JB's substantial weight gain which she also believed to be associated with the use of Clozaril.[42] According to Dr. , JB's mother researched information two weeks before JB's death which led her to have more concerns about the continued use of Clozaril.[43] She was allegedly concerned about the onset of tardive dyskinesia and sudden death associated with other psychotropic drugs.[44] Dr. stated that there was a history of sudden death in JB's family which was the cause of her concern.[45] However, JB's mother corrected this statement by stating that there is no history of sudden death, but only that a close relative had died of a heart attack.[46]

To assuage the concerns of JB's mother, Dr. told JB's mother that he would take her concerns to the next treatment team meeting (2/11/99) and a reduction in the Clozaril would be considered at that time.[47] JB's medical records show that between January 1997 and December 1998, the treatment team has discussed reductions in Ativan, Depakote, and Clozaril with to deal with the combination of JB's maladaptive and panic behaviors.[48] Dr. JB's primary care physician, also intended to discuss possible medication changes with Dr. at one psychiatric clinic in January 1997.[49] Yet the clinic recommendations do not suggest that any significant change in medication level or type of medication to specifically address JB's panic attacks despite the team's repeated documention that JB was experiencing panic and/or anxiety attacks at times.[50] The only new medication appearing in the record is Cogentin, which was prescribed to correct JB's excessive drooling.[51] There is no documentation to suggest that Dr. or Dr. considered or discussed the use of a selective serotonin re-uptake inhibitors (SSRI), the most appropriate treatment for panic disorder.[52]

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[40] SEVTC Pre-Discharge Plan – 8/98; Bimonthly QMRP Reviews
[41] Interview with JB's mother
[42] Id.
[43] Interview with Dr. , Treating Psychiatrist
[44] Id.
[45] Id.; Interview with JB's mother
[46] Interview with JB's mother
[47] Interview with Dr.
[48] Psychiatric Clinic Notes
[49] Physician I.D. Notes – 1/8/97
[50] Psychiatric Clinic Notes
[51] Id., Physician I.D. Notes – 7/24/97
[52] Psychiatric Clinic Notes; Medical Expert Report

At the February 11, 1999 treatment team meeting ("psych clinic"), JB's mother was insistent that the Clozaril was causing JB to have panic attacks and contributing to a heightened level of seizure activity.[53] JB's mother stressed her desire to have the Clozaril dosage reduced.[54] As of February 11, 1999, JB had very stable behaviors during the past five months.[55] The psychiatrist agreed to the reduction.[56]

Most of the team was hesitant to reduce the Clozaril because there was a fear that JB's self-injurious behaviors would increase and a contingency plan would have to be developed at that time.[57]The only person who flatly objected to the reduction was the Program Manager because JB had been doing well with the medication at its current level.[58] The psychiatrist, beginning on February 12, 1999, ordered a 100-mg reduction in Clozaril.

During the weekend (February 13-14, 1999) after the reduction of the Clozaril, it was reported that JB had a good weekend without any ostensible adverse reaction to the reduction in medication.[59] JB's mother came to visit him during the weekend and things were reportedly normal.[60]

On Monday, February 15, 1999, at about 1:45 p.m., Caregivers 1 and 2 took JB and other cottage residents on a walk after lunch.[61] Unusually JB is sluggish after lunch, but he was particularly excited about going for the walk.[62] The walk was leisurely and lasted one hour and a half.[63]

One hour into the walk, Caregiver 2 stated that JB started his typical signs of uncomfortability.[64] He was walking backwards towards the playground, away from the trail and he started acting anxious.[65] He laid down in the field for a while and then got up on his own. JB then got on his tiptoes and then laid down in his stomach.[66] He next began hopping on his knees.[67] JB then arched his back until the top of his head touched the sidewalk.[68]

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[53] Interview with Dr.
[54] Interview with JB's mother
[55] Interview with Treating Psychologist
[56] Interview with Dr.
[57] Interview with Treating Psychologist
[58] Interviews with JB's mother and Treating Psychologist
[59] Interview with Treating Psychologist
[60] Id.
[61] Interviews with Caregivers 1 and 2
[62] Interview with Caregiver 2
[63] Id.
[64] Id.
[65] Id.
[66] Id.
[67] Id.
[68] Id.

Caregiver 1 started talking to JB after she saw this in an effort to calm him.[69] Caregiver 2 stated that she and Caregiver 1 both took JB by the hands and tried to walk him back to the playground.[70] However, JB went down to the ground again and Caregiver 1 decided to stay with him until JB worked himself out of the episode.[71] Caregiver 2 stated that she then took the rest of the group back to the cottage.[72] Caregiver 1 stayed with JB.[73] The episode lasted about thirty minutes.[74]

After taking the children back to the cottage. Caregiver 2 allegedly looked out the cottage window and observed Caregiver 1 still working with JB on the ground.[75] Caregiver 3 called the paramedics and they arrived within a couple of minutes.[76] EMS worked on JB for several minutes, and then carried JB to Chesapeake General Hospital for emergency care.[77]

JB was pronounced dead at 5:35 p.m. by the hospital due to cardiac arrest.[78] Interestingly, all of JB's prior emergency treatment records reference anxiety attacks or panic attacks in JB's past medical history, but his February 15, 1999 visit does not.[79]

C. Additional Witness Testimony

The consulting neurologist from Eastern Virginia Medical School stated that he was asked by SEVTC, at the insistence of JB's mother, to view a videotape of JB while he was having a panic attack. The videotape showed JB in four-point restraints and with Caregiver 1 by his side. The neurologist was asked to determine whether JB was having panic attacks (behavioral and voluntary) or seizures (involuntary). The neurologist admitted that the videotape was not enough upon which to base a medical opinion, but he ruled out seizures because they are involuntary, and JB responded to Caregiver 1's calming conversation during the taping. In fact, the neurologist stated that they do not use the term "panic attack" and his consult report states that JB was exhibiting a "behavioral spell."

When asked whether Clozaril could have contributed to the onset of these spells or attacks, the neurologist stated only that he is aware that Clozaril has tremendous benefits for some, but has to be monitored weekly through blood tests. He also stated that he was not aware of any adverse reactions between Clozaril and Depakote, an effective seizure remedy.

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[69] Id.
[70] Id.
[71] Id.
[72] Id.
[73] Id.
[74] Id.
[75] Id.
[76] Id.
[77] Id.
[78] Id.; Chesapeake General Hospital Emergency Treatment Record– 2/15/99
[79] Chesapeake General Hospital Emergency Treatment Record – 2/15/99

Dr. JB's primary care physician, works with SEVTC through a contractual agreement with Eastern Virginia Medical School. She stated that she worked very closely with JB. Yet when she was questioned extensively about JB's panic attacks, concerns of JB's mother about Clozaril, grand mal seizure, attempts to treat JB's panic attacks, and potential causes of JB's death, she was not able to provide any specific information. During the interview, she referred to her notes often, and was not able to elaborate beyond what was said prior to reviewing her notes. She stated that JB did not have any diagnosed heart problems, but had been diagnosed with eczema, panic disorder, and epilepsy. JB had no major health problems.

SEVTC Medical Director, stated that he only saw JB when JB's primary care physician was not at the center, or in emergencies, or when seclusion and restraint was used. In his interview, he stated that his duties involved overall medical care for all residents. However, he did work closely with "more medically involved" patients, like those with cerebral palsy and those who are profoundly retarded. He stated that JB's primary care physician worked more with patients who are MR or dually diagnosed.

SEVTC Medical Director stated that he did not have much information to give related to JB's care. However, it is important to note that a review of the medical records showed that SEVTC's Medical Director's signature appears on several Physician I.D. notes, physical examination reports, and consultation records. SEVTC Medical Director stated that he was out of the country on February 15, 1999.

JB's Team Leader, stated that she is responsible for implementing programs, training staff, observing residents, dealing with parent issues, and consulting with physicians, and frequently has appointments off site.

The Team Leader stated that she worked very closely with JB, often accompanying him on field trips and other outings. She works in the cottage when she is not off site. She was not in the cottage on February 15, 1999.

The Team Leader stated that she had to train the staff to deal with JB's autism and how to make the environment safe for him. She stated that JB was very high functioning despite being MR and he did a lot for himself.

The Team Leader confirmed earlier testimony about JB's behaviors when he had panic-like attacks. She also stated that the treatment team was in a quandary over whether JB was actually having panic attacks, seizures or behavioral tantrums. The team had differing opinions until Xanax was used and then they knew that the episodes were behavioral. The Team Leader stated that she did not often see JB's primary care physician, but saw SEVTC Medical Director a couple a times when JB was placed in restraints. When asked about JB's schizophrenia diagnosis, the Team Leader stated that this diagnosis was necessary primarily to get JB on the Clozaril.

The Team Leader stated that JB started to gain weight so they changed his diet. She stated that they also put JB on an exercise plan in an effort to control JB's weight. JB gained 46 pounds between 1995 and 1998.[80] The Team Leader stated that JB's mother was very involved and came to the center at least four times per week.

The Team Leader stated that the treatment team had several discussions about taking JB off Clozaril. The team did not want to change the dosage because JB seemed to be benefiting from the medication. The Team Leader stated that JB was "up and down" behaviorally until the last six months of his life which seemed very happy for him.

She stated that she did not know what caused JB's death, but because the Clozaril was the only change in JB's medication, the thought had crossed her mind that the Clozaril was a factor.

The Program Manager, gave largely the same testimony as the Team eader

Caregivers 3 and 4 gave testimony as to JB's panic attacks, daily routine, and medication regimen. They confirmed other caregiver accounts of the signs of JB's panic disorder and the concerns that JB's mother had with staff and JB's continued use of Clozaril. The SEVTC's Speech Pathologist was the shift leader at JB's cottage on the day he died. However, she stated that she did not work with JB and never witnessed any of his panic attacks. She did not provide any information related to the events leading up to JB's death.

D. Autopsy and Medical Expert Reports

An autopsy was done on February 16, 1999, and a report completed on May 28, 1999, but was not provided to DRVD until June 11, 1999, despite several status requests. The Medical Examiner stated that the toxicology report and outside analysis of JB's heart caused a delay in releasing the report.

The report stated that the cause of death was "undetermined" because no toxicological or anatomical cause was demonstrated. Blood work showed positive for valproic acid (Depakote) and clozapine (Clozaril). Post-mortem blood was not analyzed.

The medical expert's report was done by an independent doctor of psychiatry and neurology. The report was based on his review of the following information: witness testimony from JB's medical team; medical summary dated February 16, 1999; emergency room report dated February 15, 1999; autopsy report; SEVTC death summary; three videotapes recorded on or about August 8, 1998; medication logs; emergency programming records from 1997; laboratory reports; interdisciplinary notes from December 1997 through February 1999; treatment plans; policies and procedures; medical examination reports; quarterly reviews; physician's orders from March 1991 through February 1999; and other documentation provided by DRVD.

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[80] Medical Expert Report

The medical expert's report stated that JB's death resulted, in substantial part, from a failure of SEVTC to recognize the presence of, and appropriately treat JB's anxiety disorder. The expert stated that the center relied on the use of a neuroleptic medication (Clozaril) for sedation, and when this sedation was removed, the anxiety disorder re-emerged and created a physiological state which likely caused JB's premature death.

The expert stated specifically that JB had a significant documented history of anxiety which was shown in the videotapes as a panic attack. The medical record contained evidence of a hyper-catecholamine state which is known to increase blood pressure, pulse rate, and can contribute to cardiac arrythmias (the presumed cause of death resulting from cardiac arrythmia). Lastly, the expert states that reducing the clozapine (Clozaril), a neuroleptic prescribed for behavioral outbursts, allowed the re-emergence of panic which compromised cardiac function. Therefore, the failure to recognize and appropriately treat JB's panic disorder, combined with the reduction in the Clozaril, contributed significantly to JB's death.

The expert's report chronicled why SEVTC staff should have had no confusion as to whether JB was having a panic attack or a seizure. On January 8, 1997, JB's primary care physician and the SEVTC health services director noted that JB had a progression of anxiety to panic like attacks which included severe hyperventilation. The expert also referenced that JB's primary care physician discussed with JB's mother that JB had "spells of hyperventilating and tensing up his muscles" and that "there is a high probability that what the staff has been witnessing are panic attacks."

The report further states that the psychiatry clinic indicated that "panic attacks" were the target of the treatment, the only psychiatric diagnosis was schizophrenia. In February 1997, JB's primary care physician noted that JB had a "history of panic attacks." In March 1998, JB hyperventilated while on a treadmill, and was subsequently given a stress test which proved normal.

In May 1998, the SEVTC staff observed JB breathing heavily, rolling his eyes back in his head, and pulling on staff. In August 1998, the neurologist observed a videotape of JB during one of his episodes and called it a "behavioral spell." Therefore, SEVTC staff started calling JB's episodes panic attacks.

The expert's further references the endocrinologist's summer 1998 consult in which he stated that "elevated catecholamines could be secondary to a panic disorder and agitation/anxiety."

The expert's opinion was that JB suffered from Panic Disorder with Agoraphobia based on the wealth of documented clinical evidence and the videotapes. The expert stated that the treatment team and SEVTC staff were not coordinated in their effort to treat JB. He further states that clinic notes did not identify Panic Disorder as a diagnosis. Residential staff and JB's primary care physician believed JB's condition to be anxiety based. Seizures were postulated, but there was no clinical evidence to support a seizure disorder.

The expert states that it is even "more disturbing" that the treatment team failed to treat the panic disorder to in turn "reduce the morbidity and mortality associated with this condition." He further adds that "[b]enzodiazapines were being used, but often tapered, and discontinued, or switched." The expert suggests that JB should have been given a "selective serotonin re-uptake inhibitor (SSRI) which is the treatment of choice for Panic Disorder."[81] The expert also states that the guidelines of the American Psychiatric Association for the treatment of Panic Disorder clearly state that SSRI's are the treatment of choice. He adds, "the result would have been positive, as it is in 80% of cases of Panic Disorder." The expert concludes by stating that "because the psychiatrist and general medical doctor were not clear on the psychiatric diagnosis, proper treatment was not rendered. This contributed significantly to the cause of JB's death. The standard of care was not met."

IV. FINDINGS AND CONCLUSION

Based on a review of the medical records, witness testimony, and the expert's report, DRVD finds that SEVTC did not provide the appropriate medical treatment and care to JB, thereby resulting in JB's sudden death on Monday, February 15, 1999. There are several reasons one would reach this conclusion.

First, JB never had a history of seizures based on JB's medical record and the admission of both JB's primary care physician and health services director in JB's Death Summary. There is only one documented seizure (1994) despite reports that reference JB having a seizure disorder.

Second, there are several instances where JB's primary care physician clearly states that JB was receiving treatment for Panic Disorder, or was experiencing a panic attack, or was exhibiting behaviors associated with panic-like attacks between 1993 and 1999.

Third, JB was taken to Chesapeake General Hospital for emergency treatment at least three times between 1996 and 1999 for panic attacks.

Fourth, JB's annual psychological update (7/3/97) clearly states that JB "continues to engage in self-injurious behaviors . . .and behaviors that resemble panic attacks" and states that incidents of panic attacks showed an increase. The update suggested that JB's environment be monitored to determine the stimuli causing JB to panic. Several of JB's psychiatric clinic reports from 1997 also state that JB suffered from panic attacks and medication was prescribed accordingly.

Fifth, the three videotapes clearly showed JB in a panicked state, unlike that of a seizure. In addition the neurologist's consult reinforced the likelihood that JB was experiencing a "behavioral spell" or panic attack instead of a seizure.

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[81] Roy-Burne, P, Stein, M, Bystritsky, A, et al. Pharmocotherapy of Panic Disorder: Guidelines for the Family Physician. *Journal of the American Board of Family Practice* 1998; 11: 282-290.

Sixth, direct care staff repeatedly described the same behaviors which were associated with the onset of a panic attack. Therefore, the treatment team had enough information to clearly make the determination that JB had been experiencing panic attacks as a result of a documented panic disorder and not seizures. These attacks were not isolated, but continual, and reported by medical staff, as well as caregivers responsible for JB's daily care.

Lastly, the medical expert's review of the evidence supports the fact that the standard of care was breached in this case due to medical neglect on the part of JB's treatment team. This neglect significantly contributed to JB's death.

Despite the fact that the medical staff on the treatment team and ER staff at Chesapeake General Hospital documented that JB was experiencing panic attacks, the record does not show how it intended to medically prevent and/or curb JB's panic attacks. Instead, SEVTC staff and treatment team decided to continue to postulate about whether JB was having panic attacks or seizures. According to JB's mother, it was only after her insistence that a neurology consult be done, that the seizure/panic attack quandary was addressed. This step should have been taken as early as 1993, when the SEVTC documented that JB was exhibiting severe anxiety and disruptiveness, and it should have been suggested by JB's psychiatrist, as head of the treatment team, or his primary care physician, as his chief medical doctor. More proactive and coordinated effort on the part of the entire treatment team may have prevented JB's death.

While it is clear that there is a legitimate basis to establish liability for medical neglect, JB's mother declined to pursue litigation at this time. However, DRVD apprised her of her rights in this matter.

V. RECOMMENDATIONS

The following recommendations are suggested based upon the above findings and conclusion:

A. SEVTC needs to acquire training for its staff and ensure that its consulting medical staff has training on the difference between symptoms and behaviors associated with Panic Disorder and Seizure Disorder. This training would elucidate the difference between the kinds of medications typically used for panic disorders and seizure disorders. It may also prevent future deaths or other resident medical complications at the training center, and strengthen the confidence of staff working with other residents who may have either condition.

B. SEVTC needs to seriously consider its continued consulting relationship with JB's primary care physician and psychiatrist. The failure of these two treatment team professionals to communicate and coordinate effective treatment and care during JB's panic episodes contributed to JB's death. A continued relationship with these

two persons may potentially result in other untimely deaths or expose SEVTC to future liability in same or similar cases where the evidence is less substantial.

C. SEVTC staff should ensure that all medical records, including videotapes, audiotapes and photographs, are maintained with the rest of a resident's on site medical records, unless the record is currently being used for consultation purposes or other extenuating circumstance. If records of this type cannot be maintained in a resident's central file, it should at least be logged there, the reason(s) it cannot be maintained there, and where it can be found upon request. This will obviate future confusion as to the existence, availability, and location of requested medical records, and the appearance of investigation obstruction.

Respectfully Submitted,

Pamela J. Johnson, Esquire
Staff Attorney

January 27, 2000
Date